Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS19ADA	A. BUILDING _____ B. WING _____	C 01/14/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTCARE NEVADA, INC. - HARRIS SPRINGS RANC	MAILING-5659 DUNCAN DRIVE LAS VEGAS, NV 89130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comment Surveyor: 21044 The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. This Statement of Deficiencies was generated as a result of the Complaint Investigation conducted from 1/7/10 to 1/14/10. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for fifty-six residential program beds for the treatment of abuse of alcohol and drugs. The youth census at the time of the incident was twelve. Complaint #NV00024108 was substantiated. See Tag D075.	D 000		
D 075 SS=G	NAC 449.114(1) Employees 1. A facility must have on duty, all hours of each day, members of the staff sufficient in number and qualifications to carry out policies, responsibilities and program continuity. This Regulation is not met as evidenced by: Surveyor: 21044 Based on interview and record review from 1/7/10 to 1/14/10, the facility did not provide adequate staff supervision for 2 of 12 male youth which resulted in sexual acts being performed on one another and the improper use of facility	D 075		

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D 075	Continued From page 1 computers. Findings include: On 1/4/10, the Bureau received a report from the facility indicating that two male youth (Resident #1 and #2) had admitted to staff that they had performed sexual acts on each other. The following is a summary of the incident: - After receiving several reports from the male youth regarding two other youth performing oral sex acts on each other, staff members interviewed Resident #1 and #2 on 1/4/10. According to an incident report written by the Program Director, both youth admitted to performing oral sex on each other on or around 12/22/09 and 12/23/09 and each youth completed written statements about the incident. - Resident #1 written statement indicated that he and Resident #2 had willingly performed oral sex on each other one night (Wednesday) and then Resident #2 wanted Resident #1 to perform oral sex on him again on the second night (Thursday), but he refused. When Resident #1 said no, he wrote that Resident #2 grabbed his right arm and then Resident #2 put his hand on his head and forced his head into Resident #2's groin and forced him to the ground. When Resident #1 was interviewed further about this statement by staff, he reported he consented to the second incident when Resident #2 pulled him to the ground. - Resident #2's statement did not reveal any details of the incident, but only offered apologies for his actions. - After reviewing the written statements and interviewing Resident #1 and Resident #2, a sexual assault call was placed with the Las Vegas Metro Police in the event that Resident #2 had forced Resident #1 to perform oral sex on	D 075		

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D 075	Continued From page 2	D 075		

him. Las Vegas Metro Police arrived and interviewed both youth. According to the incident report, the police did not have enough evidence and did not arrest either youth. Resident #1 was instructed to follow-up with the Las Vegas Metro Sexual Assault Unit in seven days.

- Both Resident #1 and #2 youth were discharged to their parents for non-compliance and were referred to outpatient counseling.

- After both residents were discharged, the staff member (Employee #1) responsible for supervising Resident #1 and #2 wrote a statement. The 1/5/10 written statement indicated approximately 15 days ago at 11:45PM, he heard foot steps coming from bedroom #1 which was shared by both youth. He wrote that he got up with his flashlight and observed both residents in the closet with Resident #1 on his knees rummaging through his laundry basket and Resident #2 looking through his clothes that were hanging in the closet. The employee then asked the boys what was going on and Resident #1 responded that he was looking for something in his jeans and Resident #2 told him he was not tired and was not ready to go to bed yet. The employee wrote that both clients were fully dressed and he instructed them to get into their pajamas and go to bed. Both complied and the employee went back to his duties and heard nothing else from the room.

- The Program Director was interviewed about the incident and she reported Employee #1 admitted to her that he had failed to conduct every 15 minute bedroom checks per policy and only checked on the two youth when he heard noises coming from their bedroom. The Program Director also stated she did not know the outcome of the sexual assault charge as both youth were discharged and Resident #1 was supposed to follow up with the sexual assault

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D 075	Continued From page 3 team, not the facility. - During the course of the facility's internal investigation, it was discovered that Resident #1 and #2 exchanged sexually explicit postings on My Space from 12/29/09 to 1/2/10 while being supervised in the facility's computer lab. The Program Director reported this was also a policy violation. Because staff failed to follow supervision policies, two male youths were able to perform sexual acts on each other on at least two occasions and send sexually explicit messages to each other using facility computers. Lack of supervision is a repeat deficiency from a 10/9/08 Complaint Investigation. Severity: 3 Scope: 1	D 075		